Family Medical History Questionnaire

Personal Information

Full Name

Date of Birth

Gender

Select

Contact Number

Family Members' Medical History

Relation	Age	Alive/Deceased	Major Illnesses	Age at Diagnosis (if any)
e.g., Father		Select		
e.g., Mother		Select		
e.g., Sibling		Select		

Family History of Specific Conditions

Has anyone in your family had (check all that apply):

- [ ] Diabetes
- [ ] Heart Disease
- [ ] Cancer
- [ ] Stroke
- [ ] Hypertension
- [ ] Other

If other, please specify

Additional Comments

Add any other relevant information here